MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: MM5050
Related Change Request (CR) #: 5050
Related CR Release Date: April 28, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R916CP
Implementation Date: October 2, 2006

Correct Reporting of Diagnosis Codes on Screening Mammography Claims

Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

Providers Action Needed

This article and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

In addition, CR5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It removes 12X type of bill (TOB) from the list of applicable TOBs for diagnostic mammography;
- It adds HCPCS code G0202 to the list of valid codes for the billing of screening mammography; and
- It adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

Implementation

The implementation date for this instruction is October 2, 2006.

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf on the CMS web site. The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR5050.

If you have questions, please contact your Medicare intermediary or carrier at their toll-free number which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.